

# CORTICOTROPHIN PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.**

**Incomplete forms will be returned for additional information.** The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit <https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth>

## PATIENT AND INSURANCE INFORMATION

Today's Date: \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:		City, State, Zip:	Patient Telephone:
BCBSTX ID Number:		Group Number:	

## PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

## PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description: \_\_\_\_\_

Medication Requested: \_\_\_\_\_ Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Quantity per Month: \_\_\_\_\_

- Is the patient currently treated with the requested agent? .....  Yes  No  
**If yes**, when was treatment with the requested agent started? \_\_\_\_\_
- Does the patient have a diagnosis of infantile spasms in the last 24 months? .....  Yes  No
- Does the patient have a diagnosis of multiple sclerosis in the last 24 months? .....  Yes  No
- Please list all agents the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products. Please specify start and end dates of drugs tried).  
 \_\_\_\_\_ Date: \_\_\_\_\_ \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_ \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_ \_\_\_\_\_ Date: \_\_\_\_\_
- Please list all other medications the patient will take **in combination** with the requested medication for the treatment of this diagnosis. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Please explain all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prescriber or Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.*

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

**Please fax or mail this form to:**

Prime Therapeutics LLC, Clinical Review Department  
2900 Ames Crossing Road Suite 200  
Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.243.6930 Phone: 855.457.0407**

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